# Humana Health Plan, Inc.
# Humana Silver 4150/Lexington UK HealthCare HMOx

**Coverage Period: 01/01/2017 - 12/31/2017**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://apps.humana.com/marketing/documents.asp?file=2882867 or by calling 1-800-833-6917.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$4,150 Individual / $8,300 Family** Doesn't apply to preventive care. Coinsurance and copayments don't count toward the **deductible**. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. **$7,150 Individual / $14,300 Family** | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, Penalties and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.humana.com or call **1-800-833-6917** for a list of Network **providers**. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |

**Questions:** Call 800-833-6917 or visit us at www.humana.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call **800-833-6917** to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **Do I need a referral to see a specialist?** | Yes. You need a referral to see a specialist. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount** you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/visit | Not Covered | ---none--- |
| | Specialist visit | $40 copay/visit | Not Covered | |
| | Other practitioner office visit | Chiropractor Exam: $20 copay/visit | Not Covered | 20 visits per year for Spinal manipulations, adjustments, modality therapy visits per calendar year. |
| | Preventive care/ screening/immunization | No charge | Not Covered | ---none--- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | Not Covered | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | Not Covered | Preauthorization may be required. Penalty will be $500. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at: www.humana.com/2017-Rx5-Plus or click here | Preferred, lowest cost generics | $10 copay (Retail)<br>$25 copay (Mail order) | Not covered | Preauthorization may be required, penalty will be 100% for certain prescription drugs.<br><br>30 day supply (Retail)<br>90 day supply (Mail Order)<br><br>Specialty drugs are not covered under the 90 day mail order benefit. |
| | Low cost generic drugs | $20 copay (Retail)<br>$50 copay (Mail order) | Not covered | |
| | Preferred brands drugs and some higher cost generic drugs | $50 copay (Retail)<br>$125 copay (Mail order) | Not covered | |
| | Brand drugs and some non-preferred highest cost generic drugs | 50% coinsurance | Not covered | |
| | Specialty drugs | 50% coinsurance | Not covered | **Specialty Drugs:** 40% coinsurance when filled via a preferred network pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | Not Covered | ---none--- |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not Covered | ---none--- |
| **If you need immediate medical attention** | Emergency room services | $600 copay per visit and deductible | $600 copay per visit and deductible | ---none--- |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | ---none--- |
| | Urgent care | $40 copay/visit | Not Covered | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | Not Covered | Preauthorization may be required. Penalty will be $500. |
| | Physician/surgeon fee | 20% coinsurance after deductible | Not Covered | ---none--- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $20 copay/office visit and 20% coinsurance after ded. for other outpatient services | Not Covered | ---none--- |
| | Mental/Behavioral health inpatient services | 20% coinsurance after deductible | Not Covered | Preauthorization may be required. Penalty will be $500. |
| | Substance use disorder outpatient services | $20 copay/office visit and 20% coinsurance after ded. for other outpatient services | Not Covered | ---none--- |
| | Substance use disorder inpatient services | 20% coinsurance after deductible | Not Covered | Preauthorization may be required. Penalty will be $500. |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance after deductible | Not Covered | ---none--- |
| | Delivery and all inpatient services | 20% coinsurance after deductible | Not Covered | ---none--- |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | Not Covered | Preauthorization may be required. Penalty will be $500. 100 visits per calendar year |
| | Rehabilitation services | PT or OT: $20 copay/visit Other providers: 20% coinsurance after deductible | Not Covered | Preauthorization may be required, penalty will be $500. 25 separate Physical (PT), Occupational (OT), Speech, Respiratory, and Orthoptic (through age 21), therapy visits per calendar year. 20 Cognitive therapy visits per calendar year. 36 Aural (post cochlear implant) therapy visits per calendar year. 36 Cardiac therapy visits per calendar year. |
| | Habilitation services | PT or OT: $20 copay/visit Other providers: 20% coinsurance after deductible | Not Covered | |
| | Skilled nursing care | 20% coinsurance after deductible | Not Covered | Preauthorization may be required. Penalty will be $500. 90 days per year. |
| | Durable medical equipment | 20% coinsurance after deductible | Not Covered | Preauthorization may be required. Penalty will be $500. |
| | Hospice service | No charge | No charge | Preauthorization may be required. Penalty will be $500. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If your child needs dental or eye care** | Eye exam | 50% coinsurance after deductible | Not covered | 1 exam per year. |
| | Glasses | 50% coinsurance after deductible | Not covered | 1 pair of lenses & frame per year. 1 additional, complete pair of eyeglasses (lenses & frame) if medically necessary. |
| | Dental check-up | Not covered | Not covered | ---none--- |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

**Other Covered Services** **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care - spinal manipulations, adjustments, and modalities
- Hearing aids - one per 36 months per hearing impaired ear
- Private-duty nursing - 250 visits of eight hours per calendar year
- Routine eye care (Adult) when in treatment for diabetes
- Routine foot care when in treatment for diabetes

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 800-833-6917. You may also contact your state insurance department at Kentucky Department of Insurance, PO Box 517, Frankfort, KY 40602-0517 - Phone: 502-564-3630 or 800-595-6053 - TDD: 800-648-6056 - Website: insurance.ky.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your state insurance department at Kentucky Department of Insurance, PO Box 517, Frankfort, KY 40602-0517 - Phone: 502-564-3630 or 800-595-6053 - TDD: 800-648-6056 - Website: insurance.ky.gov.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).**This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-833-6917.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,740
- **Patient pays** $4,800

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $4,150 |
| Copays | $20 |
| Coinsurance | $600 |
| Limits or exclusions | $30 |
| **Total** | **$4,800** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,020
- **Patient pays** $4,380

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $4,150 |
| Copays | $200 |
| Coinsurance | $10 |
| Limits or exclusions | $20 |
| **Total** | **$4,380** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use the Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Discrimination is Against the Law**

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call the number on your ID card, or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call the number on your ID card or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
**1-800–368–1019, 800-537-7697 (TDD)**
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

# Multi-Language Interpreter Services

**English:** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-320-1235 (TTY: 711)**.

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-1235 (TTY: 711)**.

**繁體中文 (Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-320-1235 （TTY: 711）**。

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-320-1235 (TTY: 711)**.

**한국어 (Korean):** 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-877-320-1235 (TTY: 711)**번으로 전화해 주십시오 .

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-320-1235 (TTY: 711)**.

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-320-1235 (телетайп: 711)**.

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-320-1235 (TTY: 711)**.

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-320-1235 (ATS : 711)**.

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-320-1235 (TTY: 711)**.

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-320-1235 (TTY: 711)**.

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-320-1235 (TTY: 711)**.

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-320-1235 (TTY: 711)**.

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-320-1235 (رقم هاتف الصم والبكم: 711).**

**日本語 (Japanese):** 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-320-1235（TTY:711)**まで、お電話にてご連絡ください。

**فارسی (Farsi):**

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-320-1235 (رقم هاتف الصم والبكم: 711).**

**Diné Bizaad (Navajo):** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-877-320-1235 (TTY: 711)**